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Women's experiences of planning a home birth with maternity care providers in middle- to high-income countries: a systematic review protocol

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REPRINT

Background: A woman's choice of birthplace does not only influence her birth experience, but also impacts on maternal and neonatal outcomes. For healthy women who have had a straightforward pregnancy, a planned home birth supported by midwives and other maternity care providers, is now a recognised choice within many individual countries' health care systems. However, there is limited evidence on women's actual experiences of engaging with maternity care providers to plan for a home birth, especially within the context of middle- to high-income countries where there is integration of maternity care services. Therefore, this systematic review will synthesise findings from previous studies, which have reported on women's experiences of planning a home birth in consultation with maternity care providers, in middle- to high-income countries. We anticipate that primarily qualitative studies will be located, as the focus of the review is on experiences of women.

Methods: Using a systematic approach, we will develop a search strategy to identify relevant research studies on women's experiences of planning a home birth, with the support of their maternity care providers.

Search terms will be iteratively developed using text words derived from the review aim, database-indexed terms and the Population, Intervention, Comparison and Outcome (PICO) framework:

- **Population:** women who planned or are planning a home birth within the context of a middle or high-income country
- **Intervention:** planning home birth with maternity care providers
- **Comparison:** none applicable
- **Outcome:** experiences.

Searches will be undertaken on seven bibliographic databases: MEDLINE, Embase, PsycInfo, CINAHL Plus, Scopus, ProQuest and Cochrane (Central and Library). Supplementary searches will also be undertaken to identify additional articles, including grey literature. At least two reviewers will do the screening, quality appraisal, data extraction and analysis. Included studies will be appraised using a quality appraisal tool suited to the study design. Data will be analysed depending on the methodological design of the studies included (that is, if all qualitative studies are included a thematic synthesis will be undertaken).

Expected outcome: Review findings will provide useful recommendations to improve care and support provided for women when planning a home birth. We will publish review findings in a peer-reviewed journal and present it at relevant conferences while also sharing summaries with maternity care providers and service users via social media fora.

Systematic review registration: PROSPERO CRD42018095042 (updated 28 September 2020).

Keywords: home birth, women, planned, childbirth, maternity care provider, experiences, Evidence Based Midwifery

Background

A woman's chosen place of birth impacts not only the type of birth, but also the number of unnecessary interventions that the mother and baby are exposed to during their labour and birth (Brocklehurst et al 2011, de Jonge et al 2015, Scarf et al 2018).

Women who give birth in a midwife-led unit or at home, rather than an obstetric unit, experience lower rates of unnecessary interventions. These include amniotomy, augmentation of labour, instrumental vaginal birth, caesarean section, and opiate or regional analgesia (Brocklehurst et al 2011, Halfdansson et al 2015, Hutton et al 2016, Reitsma et al 2020).

There is also evidence that the outcomes for both multiparous and nulliparous women and the babies of multiparous women who have birthed at home are equal to, if not better than those in other birth settings: for example, women are less likely to experience third- or fourth-degree perineal trauma, maternal infection, or postpartum haemorrhage (Brocklehurst et al 2011, Hollowell et al 2011, National Institute for Health and Care Excellence (NICE) 2014, Reitsma et al 2020).

The Birthplace in England study also reported an increased incidence of adverse outcomes for the babies of nulliparous women who had a planned home birth (Brocklehurst et al 2011). However, cohort studies on home birth have identified perinatal outcomes from home birth as low and not significantly different for infants of nulliparous women (van der Kooy et al 2011, de Jonge et al 2015).

NICE (2014) CG190 was updated in 2017 and continues to support a policy of offering all women with straightforward pregnancies a choice of birth settings including home, midwifery units (both alongside and freestanding) or obstetric unit.

Coxon et al (2017) conducted a qualitative synthesis of women's decision making for a birthplace preference and choice. The review identified that women's choice of birthplace was influenced by how informed they were about available options, their right to choose, experiences of previous births, risk perceptions, safety concerns and their care-givers' views (including family, friends and health care professionals). Planning birth at home can be enabled by following an evidence-based guideline and co-produced resources for women and their partners (Regulation and Quality Improvement Authority (RQIA) 2019).

A position statement on home birth by the International Confederation of Midwives (ICM) states that *'women have a right to home birth as a valid and safe option'* (ICM 2017:1). It also states that women have a right to make an informed decision to give birth at home supported by a midwife within their own country's health care system.

A recent joint statement by the Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG) (2020) asserts that healthy women with low-risk pregnancy may benefit from giving birth at home during the evolving COVID-19 pandemic (RCM & RCOG 2020).

In a principle-based concept analysis, Beecher et al (2019) propose a theoretical definition of 'Women's experiences of their maternity care' as:

'... a complex concept referring to women's interpretation of their care encounters within the maternity services. It is subjective in nature and evolves throughout the course of pregnancy, childbirth and the postpartum period. It is dependent upon woman's individual needs and expectations, shaped by their personal circumstances and influenced by how their care is organised and delivered.' (Beecher et al 2019:4).

In their systematic review and meta-analysis, Rietsma et al (2020) identified that women who plan to birth at home may hold different values around birth outcomes. However, they also recognised that those who plan a home birth are less likely to experience unnecessary interventions and adverse birth outcomes.

Little is known regarding women's actual experiences of engaging with maternity care providers to plan for a home birth. The dynamics of the woman–health care provider relationship in planning for a home birth within the context of a middle- to high-income country, where women have access to an integrated community and hospital maternity care system, is worthy of investigation.

Previous reviews have looked at maternal and neonatal outcomes (Catling-Paull et al 2013, Elder et al 2016, Kobayashi et al 2017, Scarf et al 2018) and comparison between planned hospital and planned home births (Olsen & Clausen 2012, Rossi & Prefumo 2018). Others have examined post-partum issues (Pantoja et al, 2016), model of care for childbearing women (Sandall et al 2016), integration of home birth into a health care system (Comeau et al 2018) and scope of hospital transfers during homebirth (Blix et al 2014, Vedam et al 2014). A recent review by Hill (2020) looked at women's experiences of planned home birth. This review used the Sample, Phenomenon of Interest, Design, Evaluation, Research (SPIDER) framework (Cooke et al 2012) and included only four papers. The review was not focused on the experience of planning home birth with maternity care providers.

A systematic review of studies on women's experiences of planning a home birth is needed to provide an in-depth understanding of what matters to women, including their information and support needs. Insights gleaned from this proposed systematic review could potentially help to enhance woman–health care provider interactions in planning for a

home birth and inform future service provision to maximise positive experiences for women, planning to birth their babies at home. Therefore, the aim of this systematic review is to synthesise findings from previous studies which have reported on women's experiences of planning a home birth in consultation with maternity care providers in middle- to high-income countries. The review question is: 'What are women's experiences of planning a home birth in consultation with maternity care providers in middle- to high-income countries?'

Methods

An important starting point for any review is operational definitions of the concepts under review. Given the rise in literature reporting on unassisted or free birthing, on Babies Born before Arrival (BBA's) to hospital, and the increased visibility of birthing supported by unregistered attendants, operational definitions of planned home birth and maternity care providers are central.

Operational definition of terms

We use the following definitions:

Planned home birth: an informed decision by women to birth their baby at home with the support of maternity care providers.

Maternity care providers: health care providers involved in supporting women to plan their birth at home. These will include midwives, obstetricians, general practitioners, (GPs) anaesthetists, paediatricians, and paramedics.

Country classifications for middle- and high-income countries

The organisation of health care differs between countries and between low- and middle-income countries and middle- and high-income countries. The focus of this review is on middle- and high-income countries. The classifications used are provided below.

Country classifications

According to the World Bank classification, high-income countries (also known as developed countries) are countries with per capita gross national income (GNI) of at least US\$12,476 as of 2018 (World Bank 2020). For example, Argentina, Australia, Barbados, Canada, Chile, Croatia, Denmark, New Zealand, France, Germany, Finland, Portugal, Spain, Sweden, Switzerland, United Kingdom, United States of America.

Middle-income countries have per capita GNI of between US\$1025 and US\$12,476 as of 2018. For example, Angola, Bangladesh, China, Cameroon, Ghana, India, Kenya, Indonesia, Nigeria, Pakistan, Philippines, Sri Lanka, Republic of the Sudan, Tunisia, Vietnam, Zambia.

Low-income countries are those with GNI per capita of US\$1025 or less as of 2018. For example, Afghanistan, Benin, Burkina Faso, Burundi, Central African Republic, Chad, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Guinea, Guinea Bissau, Haiti, Korea, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Niger, Rwanda, Sierra Leone, Somalia, Republic of South Sudan, Tajikistan, Syria, Tanzania, Togo, Uganda, Republic of Yemen.

Search strategy

Using a systematic approach (Centre for Reviews and Dissemination 2009), we will develop a search strategy to identify relevant research studies on women's experiences of planning a home birth, with the support of their maternity care providers.

Search terms will be iteratively developed using text words derived from the review aim, the PICO framework (Thomas et al 2019) (see Table 1), and database-indexed terms. Broadly, search terms will be words related to: (home birth OR childbirth) AND plan AND experience (see Appendix 1 for a sample draft of the MEDLINE search).

Table 1. PICO framework

Population	Inclusion criteria
	Women who planned, or are planning, a home birth within the context of a middle- or high-income country in consultation with maternity care providers.
	Exclusion criteria
	<ul style="list-style-type: none"> • Women who had an unplanned or unassisted/free home birth • Women planning a home birth without consulting a professional maternity care provider • Women who planned, or are planning, a home birth within the context of a low-income country (low-income countries are excluded because their health care provision or context is different to that of middle- to high-income countries).
Intervention/exposure	Primary studies which: <ul style="list-style-type: none"> • Focus on the planning phase of the home birth experience for women (planned home birth as defined above) and • Report on women's experiences of planning their home birth with their maternity care providers
Comparison	Not applicable
Outcome(s)	(i) Women's experiences of planning a home birth (ii) Women's perceptions of their consultation with maternity care providers to plan a home birth

We will test and refine the search strategy for accuracy on MEDLINE prior to running it on other databases, as appropriate. The refined search strategy will be utilised on seven bibliographic databases: MEDLINE, Embase, PsycInfo, CINAHL Plus, Scopus, ProQuest and Cochrane (Central and Library) from January 2015.

January 2015 was chosen as our cut-off point for the searches as the publication of the NICE clinical guideline (CG190) *Intrapartum care for healthy women and babies*, which advocated for home birth as a choice of place of birth for women, was December 2014 (NICE 2014). Evidence previous to January 2015 would, therefore, have been utilised to develop the guideline.

In line with the Peer Review of Electronic Search Strategies (PRESS) guidelines, we will develop the search strategy in consultation with an experienced subject librarian, which will be checked by at least two authors.

We will tailor the refined search terms to each database's indexing requirement. Boolean operators 'AND' and 'OR' will be used to combine search terms as appropriate. We will also use quotation (") and truncation (*) marks to capture possible variations of the search terms on each database. We will further conduct supplementary searches to identify additional articles, which we may have missed during the electronic database searches. This will include back-chain referencing of included papers (hand searching of reference lists), consultation with members of the *Planning to birth at home in Northern Ireland* (RQIA 2019) guideline development group, professional networks and grey literature search (for example, OpenGrey).

We will run the searches again on the selected databases prior to the final analysis to identify any newly published articles. We will manage search results with the bibliographic databases Endnote, Refworks and Covidence. Deduplication of retrieved articles will be undertaken on Endnote and Covidence using a systematic method (Bramer et al 2016).

The review is registered on the International Prospective Register of Systematic Reviews (PROSPERO CRD42018095042, updated 28 September 2020).

Identification and selection of studies

Studies will be identified and selected based on the following inclusion and exclusion criteria:

Inclusion criteria

Primary studies, which investigated women's experiences of planning a home birth within the context of middle- and high-income countries, reported in the English language and published from January 2015 will be included. Studies that report

on women's experience and/or perceptions of their consultation with maternity care providers when planning a home birth will also be included.

Exclusion criteria

We will exclude grey literature which lacks a clear methodology (for example, editorials and books) and conference abstracts if full papers cannot be accessed and PhD and MSc dissertations. We will exclude studies focused on health care professionals' or partners' views on home birth planning. We will exclude home birth studies that lack clear separate data on women's experiences of the planning phase of the home birth, and studies conducted in low-income countries.

Screening

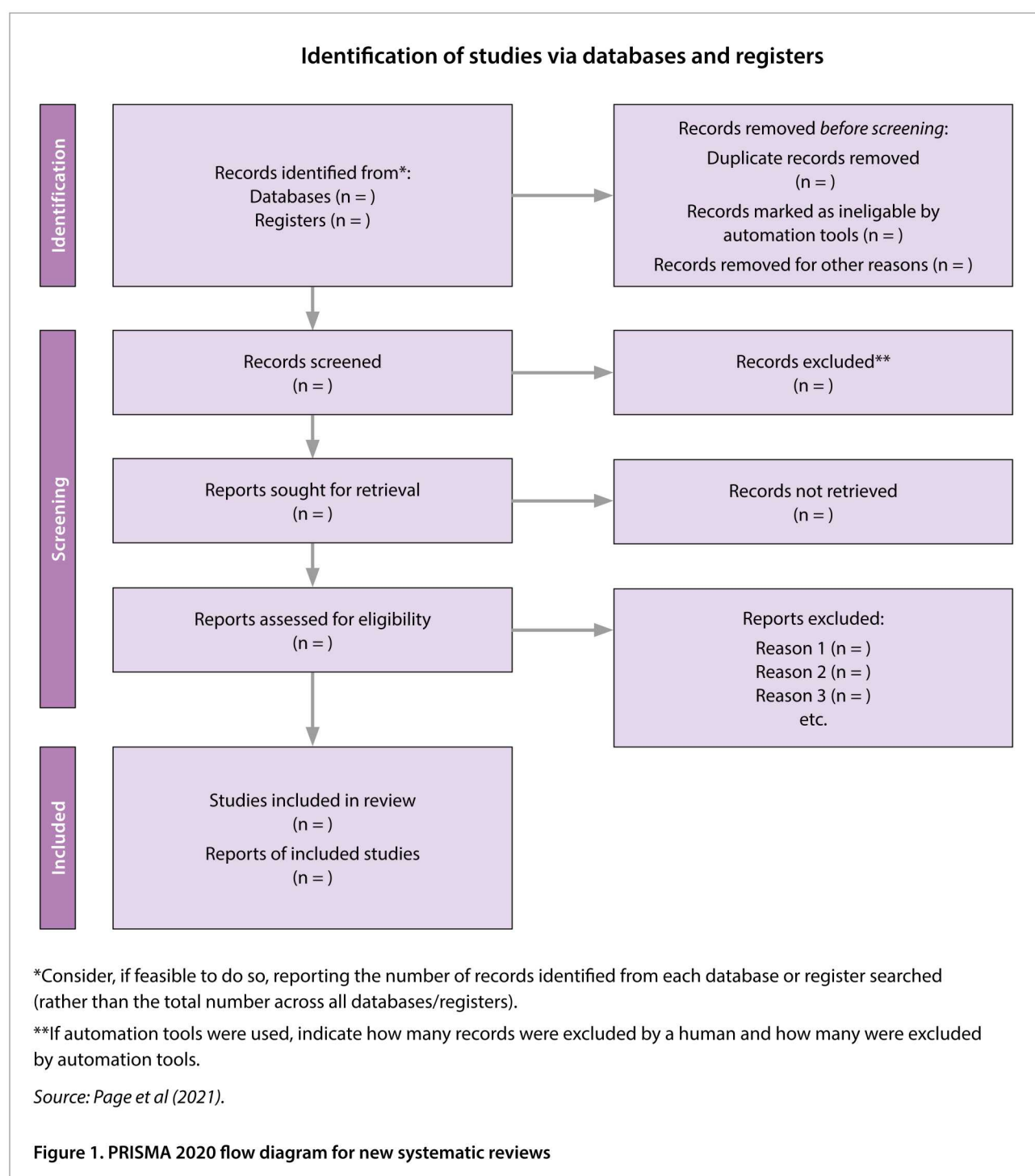
Following deduplication on Endnote, we will upload the remaining articles into Cochrane's systematic review management software to manage the screening process in a rigorous and transparent approach in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines (Page et al 2021).

At least two reviewers (PG, MH or OB) will independently screen the titles and abstracts of retrieved studies to remove irrelevant articles. Two authors will resolve any conflicts and, if not possible, a third author will review and then all three authors will reach agreement. Two authors (PG, MH or OB) will then screen the full text of potentially relevant articles against the review's inclusion and exclusion criteria. We will resolve differences in opinion through discussion (by a minimum of two authors) to reach a mutual agreement. We will report the study selection process on a Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) diagram (see Figure 1).

Quality appraisal

At least two reviewers (PG, MH, or OB) will independently appraise the quality of the included studies using an appraisal tool relevant to each study's methodological design. We will appraise studies using the Critical Appraisal Skills Programme tool suited to each study's design (CASP 2020). For example, qualitative studies will be assessed using the CASP tool for qualitative studies. We will appraise randomised controlled trial (RCT) studies (if included), using the CASP tool for RCTs, although we do not expect to find any RCTs due to the nature of the review question.

We will assess other quantitative studies (non-RCTs), using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) tool (Guyatt et al 2008). Mixed methods studies will be assessed using the Mixed Methods Appraisal (MMAT) tool (Hong et al 2018). We will assess risk of bias in



RCTs (if included) using the Cochrane risk of bias tool (Higgins et al 2021) and the Confidence in the Evidence for Reviews of Qualitative Research (CERQual) tool for qualitative studies (Lewin et al 2018).

Data extraction

At least two reviewers will extract data using a standardised form on MS Excel or MS Word. Conflicts will be resolved through discussion. We will systematically extract data on outcomes related to women's experiences on planning a home birth with their maternity care providers. We will extract data

on the study title, author(s) and year of publication, study setting, methodology, population, key findings, quality appraisal score and key conclusions. Where possible, we will attempt to retrieve missing data in relevant studies by contacting the corresponding author.

Data analysis

At least two reviewers will analyse aggregate data from the final included studies and resolve any conflict through discussion. The approach for data analysis will be determined by the methodological design of the included studies. If the included studies

are quantitative and qualitative, we will integrate the findings, however, if all the studies are qualitative a thematic synthesis will be undertaken according to Thomas & Harden (2008). NVivo 12 software will be used to manage the data analysis process where appropriate.

Discussion

Findings will be discussed in relation to existing research. Review findings will provide useful recommendations to improve the experiences of women planning a home birth. We will publish the review findings in a peer-reviewed journal, and present at relevant conferences while also sharing summaries with maternity care providers and service users via social media fora.

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Conflicts of interest

The authors declare they have no competing interests.

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access to Covidence, which is Cochrane's web-based software platform, which improves the efficiency of producing systematic reviews.

The funders were not involved in collection, analysis and interpretation of the data.

Ethical approval

This is a protocol for a systematic review which utilises published data therefore ethical approval was not required.

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Contributions

PG and MH conceived and designed the review. All authors (MH, OB and PG) contributed to the writing of the protocol and will contribute to the collection, analysis and interpretation of the data. PG is the guarantor of the review.

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Appendix 1. Sample draft of search strategy on MEDLINE.

1. (home adj3 birth\$).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
2. home childbirth\$.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
3. homebirth\$.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
4. (place adj3 birth\$).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
5. home delivery/
6. (home adj3 deliver\$).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
7. 1 or 2 or 3 or 4 or 5 or 6
8. plan\$.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
9. 7 and 8
10. limit 9 to yr="2015 -Current"
11. limit 10 to English language
12. exp Communication/
13. experience*.mp.
14. "Referral and Consultation"/
15. consultation.mp.
16. Social Perception/
17. perception*.mp.
18. 12 or 13 or 14 or 15 or 16 or 17
19. 11 and 18